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A case for establishing complicated grief as a distinct mental disorder in *DSM-V*

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Abstract

In this paper, we contend that complicated grief (CG) constitutes a distinct psychopathological diagnostic entity and thus warrants a place in standardized psychiatric diagnostic taxonomies. CG is characterized by a unique pattern of symptoms following bereavement that are typically slow to resolve and can persist for years if left untreated. This paper will demonstrate that existing diagnoses are not sufficient, as the phenomenology, risk factors, clinical correlates, course, and outcomes for CG are distinct from those of posttraumatic stress disorder (PTSD), major depressive disorder (MDD), and adjustment disorder (AD). It is argued that the establishment of CG as a diagnostic entity is essential because its symptoms are associated with enduring mental and physical health morbidity and require specifically designed clinical interventions. We conduct a critical review of all published evidence on this topic to date, demonstrating that the advantages of standardizing the diagnostic criteria of CG outweigh the disadvantages. In addition, recommendations for future lines of research are made. This paper concludes that CG must be established in the current nosology to address the needs of individuals who are significantly suffering and impaired by this disorder.

Keywords: Grief; Diagnosis; Diagnostic and Statistical Manual; Taxonomies; Mental disorders

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1. Introduction

For years, researchers and clinicians alike have documented numerous mental and physical health complications associated with bereavement. The symptoms have included, but have not been limited to, depression, anxiety, interpersonal problems, substance abuse, hallucinations, physical illness, and even death (cf. Sable, 1992; Stroebe, Schut, & Finkenauer, 2001). Rather than focusing on the vast range of complications that can arise following bereavement, this paper will argue for the establishment of a distinct set of symptoms as a specific mental disorder, complicated grief (CG), that should be included in future editions of mental disorder classification systems, such as the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*).

Recent research efforts have advanced promising empirically derived diagnostic criteria to define CG, and in addition have explored its associated features and potential treatments. The current paper demonstrates that the symptoms of CG constitute a disorder that is distinct from posttraumatic stress disorder (PTSD), bereavement-related depression or major depressive disorder (MDD), and adjustment disorder (AD) by exploring its unique qualitative nature. Furthermore, the symptoms of CG are associated with mental and physical dysfunction that can persist for years and even decades if untreated. If the criteria of CG are not formally established, research to determine efficacious and effective interventions will be hindered. After presenting evidence of the distinctiveness of this disorder (see Table 1 for a summary of studies), a review and synthesis of this information will be conducted to demonstrate the merits of establishing CG as a unique diagnosis in the current nosology of mental disorders.

2. The classification of CG

2.1. The classification of mental disorders in the DSM

Currently, most mental health professionals in North America rely on the definitions of mental disorders set forth by the *Diagnostic and Statistical Manual of Mental Disorders—4th Edition, Text Revision* (*DSM-IV-TR*; American Psychiatric Association, 2000). The *DSM* has undergone several revisions since its creation in 1952, and decisions to insert new diagnoses in the manual are based on research demonstrating evidence for their inclusion (American Psychiatric Association, 2000). Although it admittedly lacks an operational definition of "mental disorder," the *DSM* continues to offer guidance in the distinction between normal and pathological. The American Psychiatric Association (2000) describes it as follows:

> In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. (p. xxxi)

2.2. The consideration of grief in the DSM

The task of establishing diagnostic criteria for CG involves demonstrating that its symptoms are associated with distress or disability and are distinct from those that are "expectable and culturally

Table 1
Studies demonstrating the distinctiveness of CG

	Study authors	Major findings	Methods used	Findings replicated?
Distinctive symptoms/ phenomenology	Prigerson, Frank, et al. (1995)	CG unidimensional construct distinct from depression	Principal components analysis	Yes
	Prigerson, Maciejewski, et al. (1995)	CG unidimensional construct; ICG empirical validation	Exploratory factor analysis; purifying analysis	Yes
	Prigerson, Bierhals, et al. (1996)	CG unidimensional construct distinct from depression and anxiety	Principal axis factoring	Yes
	Prigerson, Shear, et al. (1996)	CG unidimensional construct distinct from depression and anxiety	Confirmatory factor analysis	Yes
	Horowitz et al. (1997)	Symptom indicators of CG; CG and MDD symptoms often did not overlap	Latent class modeling; signal detection	No
	Chen et al. (1999)	CG unidimensional construct distinct from depression and anxiety	Principal axis factoring	Yes
	Prigerson, Shear, et al. (1999)	Symptom indicators of CG	Signal detection	Yes
	Boelen, van den Bout, and de Keijser (2003)	CG unidimensional construct distinct from depression and anxiety	Principal axis factoring	Yes
	Ogrodniczuk et al. (2003)	Three symptoms clusters of CG distinct from two symptoms clusters of depression	Factor analysis	No
Distinctive risk factors/ etiology/clinical correlates	Beery et al. (1997)	Caregiver burden predicted CG but not depressive symptoms	Regression analysis	No
	McDermott et al. (1997)	Sleep disturbances associated with PTSD and MDD not related to CG	ANOVA; correlational and regression analysis	No
	Maercker et al. (1998)	Fewer positive themes at 6 months postloss predicted CG-like symptoms at 14 months	Regression analysis	No
	van Doorn et al. (1998)	Close, security-enhancing relationship and insecure attachment styles predicted CG and not depression	Regression analysis	Yes
	Chen et al. (1999)	Women reported more CG than men within first 2 years	Repeated-measures ANOVA	No
	Carr et al. (2000)	High levels of yearning associated with increased marital closeness and dependence	Regression analysis	Yes
	Prigerson et al. (2001)	Less mental health care service utilization among patients with CG versus MDE	Regression analysis	No

(continued on next page)

Table 1 (*continued*)

	Study authors	Major findings	Methods used	Findings replicated?
Distinctive risk factors /etiology/clinical correlates	Silverman et al. (2001)	Childhood adversity predicted CG, whereas adult adversity predicts PTSD	Regression analysis	No
	Barry et al. (2002)	Lack of preparedness for death predicted CG but not MDD or PTSD	Regression analysis	No
	Prigerson et al. (2002)	Pakistani women more likely to meet criteria for CG than men; first-degree relative more likely to meet criteria	Regression analysis	No
	Vanderwerker et al. (submitted for publication)	Child separation anxiety predicted CG, but not MDD, PTSD, or generalized anxiety disorder	Regression analysis	No
Independent outcomes	Prigerson, Frank, et al. (1995)	CG but not MDD predicted global functioning, depressed mood, and sleep quality at 18 months	Regression analysis	Yes
	Prigerson, Shear, et al. (1996)	CG at 6 months independently predicted depression at 12 and 18 months	Regression analysis	Yes
	Prigerson, Bierhals, et al. (1997)	CG at 6 months predicted cancer, high blood pressure, heart trouble, change in smoking/ eating habits, and suicidal ideation at 13 and/ or 25 months; CG at 6 months better predictor of morbidity than at 2 months	Survival analysis; regression analysis	Yes
	Szanto et al. (1997)	Greater CG among suicidal ideators; active ideators had greater CG than passive	χ^2 tests; ANOVA	Yes
	Chen et al. (1999)	CG predicted health events a 13-month follow-up (e.g., cancer, heart attack, hospitalization, and accident); gender differences in predicted outcomes	Regression analysis	Yes
	Prigerson, Bridge, et al. (1999)	Young adults with CG after losing friend to suicide 5× more likely to report suicidal ideation, controlling for depression	Regression analysis	Yes
	Silverman et al. (2000)	CG diagnosis related to poorer quality of life; CG better predictor than MDE or PTSD	Regression analysis	Yes

	Prigerson, Silverman, et al. (2001)	Individual with CG but not MDE had higher functional disability and were 10× more likely to have high blood pressure than those without CG	Regression analysis	Yes
	Latham and Prigerson (2004)	CG associated with 6.6× greater likelihood of high suicidality at baseline and 11.3× greater likelihood at follow-up; CG at baseline predicted an 8.2× greater likelihood of high suicidality at follow-up	Regression analysis	Yes
Diagnostic discrimination	Prigerson, Frank, et al. (1995)	46% with CG did not meet criteria for MDD	Contingency table analysis	Yes
	Horowitz et al. (1997)	79% with CG did not meet criteria for MDD	Contingency table analysis	Yes
	Silverman et al. (2000)	63% with CG did not meet criteria for PTSD; 50% with CG did not meet criteria for MDE	Contingency table analysis	Yes
	Silverman et al. (2001)	18% met criteria for a diagnosis of CG, whereas 7% met criteria for PTSD and 12% for MDE; CG lowest comorbidity rate and most prevalent	Contingency table analysis	Yes
Distinctive course /treatment response	Pasternak et al. (1991)	Depressive but not CG symptoms improved with nortriptyline treatment	ANOVA	Yes
	Pasternak et al. (1993)	Grief symptoms more stable than depressive symptoms	ANOVA	Yes
	Prigerson, Frank, et al. (1995)	Depressive but not CG symptoms improved with nortriptyline treatment	Repeated-measures ANOVA	Yes
	Bierhals et al. (1995–1996)	CG symptoms stable in first 3 years, but then increase among men and decrease among women	ANOVA; *t* tests	No
	Reynolds et al. (1999)	Depressive but not CG symptoms improved with nortriptyline and combination of nortriptyline and IPT	χ^2 tests	Yes
	Ott (2003)	Mental health status of individuals with CG improved less over time than that of individuals without CG over 18 months	Repeated-measures ANOVA	No

sanctioned" as a response to the death of a loved one, as cited above. But is that sufficient? Might some individuals argue that CG could be subsumed by an existing diagnostic category, such as PTSD? A problem with this is that bereavement and trauma do not always overlap. Stroebe et al. (2001) described several positions on the interaction between bereavement and trauma that exist in the scientific community. One position focuses on the phenomenology of the bereavement reaction rather than on the type of stressor event involved, and posits that bereavement and trauma should be distinct (Pynoos, Nader, Frederick, Gonda, & Stuber, 1987; Raphael & Martinek, 1997). Another position states bereavement should be considered a traumatic event, and therefore pathological grief ought to fall under the rubric of PTSD (Figley, Bride, & Mazza, 1997; Simpson, 1997). A third opinion considers the overlap between bereavement and trauma, and proposes that a diagnostic category of "traumatic grief" should be developed based on the nature of the death event (Green, 2000; Rando, 2000). Finally, there is the view that pathological grief is a potential consequence of both traumatic and nontraumatic bereavements (Horowitz et al., 1997; Jacobs, 1993; Prigerson & Jacobs, 2001a). This last position is the focus of recent research on CG as it is conceptualized in the current paper.

Stroebe et al. (2000) observed that between the third and fourth editions of the *DSM*, there was greater recognition of grief as potentially pathological. In the revised third edition of *DSM* (*DSM-III-R*; American Psychiatric Association, 1987), the listing of Uncomplicated Bereavement suggested that bereavement-related depression is a normal reaction, as opposed to one of the complicated disorders that frequently develops following a loss (Rosenzweig, Prigerson, Miller, & Reynolds, 1997). Currently, in *DSM-IV-TR* (2000), the PTSD traumatic stressor criterion permits diagnosis following learning of the death or threat of death of a loved one. Uncomplicated Bereavement has been removed, and Bereavement is currently listed as a "V" (V62.82) code under, "Other Conditions That May Be a Focus of Clinical Attention" (American Psychiatric Association, 2000). These changes are promising and suggest that *DSM-IV-TR* (2000) recognizes that grief symptoms may warrant clinical attention. Despite this progress, however, the *DSM* still does not acknowledge the unique symptoms that constitute a CG diagnosis.

2.3. Current approaches to diagnosing grief-related pathology

Without standardized diagnostic criteria for pathological grief symptoms, clinicians have been forced to rely on existing diagnoses to facilitate case conceptualizations and treatment of their clients. Marwit (1991, 1996) found that clinicians relying on diagnoses outlined in *DSM-III-R* (1987) were forced to match grief symptoms to a broad range of disorders: dysthymic disorder, MDD, bipolar disorder, schizoaffective disorder, uncomplicated bereavement, PTSD, AD with depression, AD with mixed emotional features, brief psychotic reaction, obsessive–compulsive disorder, dissociative disorder, and borderline personality disorder. He found that clinicians actually demonstrated higher interrater reliability when using classifications, such as masked and chronic grief derived from the thanatological literature (see Worden, 1986), than when using those from the *DSM-III-R* (1987).

It is important to note that no other set of negative cognitive, emotional, and behavioral symptoms are considered *normal* like those that comprise reactions to loss. Many of the negative symptoms are expected and typical however, grief does involve suffering and frequently involves functional impairment, and is it not suffering and impairment that guide the clinician in diagnosing a disorder? So

when does a reaction shift from normal to pathological? What is the motivation behind diagnosing someone with this disorder? To address these questions, this paper focuses on current conceptualizations of CG in which the proposed symptoms of CG consist of both traumatic distress and separation distress phenomena, but do not apply exclusively to traumatic losses (Prigerson & Jacobs, 2001a; Stroebe et al., 2001). Both traumatic and separation distress symptoms cluster into a unitary factor, suggesting they are best conceptualized as a singular disorder (Prigerson et al., 1995; Prigerson, et al., 1995). Furthermore, the unique symptoms of CG are not captured by the symptom criteria of current mental disorders and appear to be related to long-term mental and physical morbidity. Therefore, existing diagnoses are insufficient, and CG should be established as a new mental disorder in the standard diagnostic manuals.

3. Defining CG

3.1. Normal versus "complicated" grief

One of the salient obstacles in establishing a consensus about the phenomenology of CG is the difficulty in distinguishing between normal and complicated mourning (Sable, 1992). Theorists have frequently characterized normal, uncomplicated grief as a dynamic process with overlapping stages, some of which include shock, painful emotional and somatic symptoms, and then resolution (Bowlby, 1980; Engle, 1961; Ringdal, Jordhoy, Ringdal & Kaasa, 2001). In the past, pathological grief was conceptualized as the failure to pass through the necessary stages (Engle, 1961). Contrary to popular belief shaped by early theorists, the current common view is that bonds with the deceased may dissolve, but do not need to be severed in order for recovery to occur; grief is expected to dissipate with time (Marwit & Klass, 1995; Ringdal et al., 2001). Recent research studies examining the proposed stage theories of grief have not found evidence supporting the resolution of grief by clearly cut stages. Rather, symptoms and proposed phases often overlap with one another, and most symptomatic distress appears to rise and fall in a parallel, or synchronized, fashion (Prigerson & Jacobs, 2001b).

It is widely recognized that symptoms of normal grief are similar to those of depression, anxiety, and posttraumatic stress, consequently making it challenging to distinguish between normal and psychopathological responses. The differences between CG and other mental disorders are further obscured because individuals vary in the number of pathological symptoms they may experience following a loss (Rosenzweig, 1997). Horowitz et al. (1993) emphasized the continuum on which both normal and pathological grief lie by characterizing the latter as, for example, an intensification or prolongation of the norm. However, there are numerous more formal standards that may be used to distinguish pathological from normal grief symptoms, including statistical, duration, intensity, differential symptom, and disruption of function criteria (Stroebe et al., 2000).

3.2. Naming the disorder

Clinicians, researchers, and theorists have previously described CG, or some variant of it, by countless terms and subtypes. Marwit (1996) stated that "complicated" has been used as a modifier rather than "abnormal" or "pathological" because it is difficult to agree on the boundaries of normal grief, and it is

unclear whether or not CG reflects an inherently pathological state. To eliminate the proliferation of terms, two research teams in particular have focused on establishing a single diagnostic entity (Horowitz, Bonanno, & Holen, 1993; Horowitz et al., 1997; Prigerson, Frank, et al., 1995; Prigerson & Jacobs, 2001a). Prigerson, Frank, et al. (1995) chose the indicator, "complicated," because it reflects the unresolved nature of the disorder and because its symptoms are related to complications in normal functioning. Although CG was referred to as traumatic grief (Prigerson, Bierhals, et al., 1997; Shear et al., 2001; Silverman, Johnson, & Prigerson, 2001) until recently, it will be indicated by the term, complicated grief, for the remainder of this paper to minimize the confusion that has pervaded research on this topic in the past. Prigerson et al. reverted to use of CG after 9/11, when the confusion created by using the descriptor, "traumatic," was made abundantly clear. Many people misinterpret traumatic grief as a form of PTSD. The term, complicated grief, better clarified, rather than blurred, the distinction between the criteria outlined for CG and those established for PTSD.

3.3. Empirically validated symptom criteria

There are clearly numerous phenomena that could be considered complications of grief. However, only a subset of researchers has developed CG symptom criteria empirically (Enright & Marwit, 2002; Horowitz et al., 1997; Marwit, 1996; Prigerson, Frank, et al., 1995; Prigerson, Bierhals, et al., 1996). In 1993, Horowitz, Bonanno, and Holen argued that "pathological grief disorder" should be a separate diagnosis in the fourth edition of *DSM* (*DSM-IV*; American Psychiatric Association, 1994), which was in development at the time. They proposed that a single category should be developed (as opposed to the multiple subtypes proposed by others) to prevent further confusion and to facilitate research. Their criteria included symptoms of intrusion, avoidance, and dysfunctional adaptation. Dysfunctional adaptation involved failure to resume responsibilities and/or somatic symptoms beyond 1 month after bereavement, and/or failure to form new relationships beyond 13 months after bereavement. The individual's unique belief system and social context were to be considered when making functional impairment assessments. Horowitz, Bonanno, and Holen (1993) emphasized that symptoms that may be related to spiritual belief systems (e.g., pseudohallucinations) should not be included as criteria in diagnosing CG or any mental disorder.

Horowitz et al. (1997) continued to lobby for the classification of CG in the *DSM* and highlighted the necessity of conducting longitudinal clinical investigations towards this goal. One study conducted by their team demonstrated that prolonged grief reactions were characterized by intrusions, avoidances, and problems with adaptation to the loss (Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum, 1984). Based on the findings of this study, Horowitz and et al. (1997) constructed operational definitions of these symptoms and created a structured diagnostic interview evaluating 30 potential symptoms of CG as a supplement to the Structured Clinical Interview for *DSM-III-R*—Non-Patient Edition (SCID-NP; Spitzer, Williams, Gibbon, & First, 1990). They administered this interview module along with self-report measures to examine bereaved spouses and partners 6 and 14 months following the loss of their significant other. The 30 symptoms were divided into three categories: avoidance, intrusion, and failure to adapt; and these categories exhibited low to satisfactory internal consistency.

Horowitz et al. (1997) then used a latent class model to develop a "gold standard" for the diagnosis of CG based on observed data from four measures of CG symptoms. These measures included scores on two self-report grief symptom inventories, the number of symptoms endorsed by clinical interviewers, and global ratings of the presence/absence of CG made by clinicians. The assumption

was that these assessment tools overlapped in identifying true and false positives and negatives. The authors found that an above-median number of clinician-endorsed severe grief symptoms from the SCID-NP best estimated the latent diagnostic criteria model at both 6 and 14 months postloss (Horowitz et al., 1997). The 30 candidate symptoms were then compared to the "gold standard" criteria using signal detection analyses to determine which items best predicted CG while attempting to balance sensitivity and specificity.

At 6 months postloss, Horowitz et al. (1997) found that CG was defined by the presence of at least one of either decreased interest in important activities or strong spells of emotion, plus the presence of at least one of either unbidden memories or feelings of aloneness/emptiness. At 14 months postloss, CG was defined by the presence of either a strong yearning for the deceased, feelings of aloneness/emptiness, trouble sleeping, or strong avoidance of reminders of the deceased. Although the predictive symptoms differed at these two assessment points, the group of individuals demonstrating severe symptoms remained fairly consistent. The researchers proposed conservative diagnostic criteria that, based on their exploratory analyses, would require the presence of at least three of the seven symptoms identified by signal detection using the 6- and 14-month postloss assessment data. The criteria also required symptoms to be present for at least 1 month at least 14 months postloss. A 12-month criterion was not used because of expected reactions around the first anniversary of the death (see Horowitz et al., 1997 for proposed criteria).

Another team of researchers, Prigerson, Frank, et al. (1995), also began to empirically evaluate symptoms of CG after observing a cluster of symptoms following bereavement as qualitatively different than those of bereavement-related depression and anxiety. They evaluated symptoms that were associated with poorer adjustment in prior bereavement studies; that were clinically and intuitively related to long-term dysfunction; and that clustered together in a principal components analysis with varimax rotation, but that were separate from depressive symptoms. A review of the literature yielded a list of 12 depressive symptoms associated with poor bereavement-related outcome, including depressed mood, guilt, hypochondriasis, damage to self-esteem, worthlessness, suicidal ideation, psychomotor retardation, apathy, loneliness, pessimism, anxiety, and insomnia. There were 10 grief-related symptoms that were considered maladaptive, including crying, difficulty accepting the loss, preoccupation with thoughts of the deceased, anger, lack of closure, yearning for the deceased, searching for the deceased, disbelief, numbness, and being stunned by the loss. These symptoms were assessed in a sample of late-life widows and widowers using an assessment instrument composed of items from a variety of scales. The researchers conducted a principal components analysis of 18 of the 22 original symptoms (hopelessness, worthlessness, numbness, and lack of closure were deleted because they loaded poorly on the depression and CG factors). Factor 1, accounting for 26.2% of the variance, was interpreted as the bereavement-related depression factor; and Factor 2, accounting for 20.0% of the variance, was interpreted as the CG factor. Yearning for and preoccupation with thoughts of the deceased loaded most heavily onto the CG factor, suggesting these are key features of CG. This team and others have since replicated these findings (see Table 1). In addition, they have developed an empirically validated instrument, the Inventory of Complicated Grief (ICG; Prigerson, Maciejewski, et al., 1995), to assess the symptoms of CG.

In January 1997, a panel of experts in the fields of bereavement, trauma, and psychiatric nosology met to discuss the advantages and disadvantages of establishing diagnostic criteria for CG (Jacobs & Prigerson, 2000; Prigerson, et al., 2000). After reviewing the existing empirical research, the group concluded that there was significant evidence to substantiate the development of diagnostic criteria for

CG based on the following: (1) there were clusters of symptoms of separation and traumatic distress that were distinct from bereavement-related depression and anxiety; (2) these symptoms could persist several years for a subset of the population; (3) these symptoms were not alleviated with interpersonal psychotherapy alone or in combination with the tricyclic antidepressant, nortriptyline; and (4) these symptoms predicted significant mental and physical morbidity over and above depressive symptoms. These symptoms are also associated with difficulties in resuming prebereavement states of functioning and are regarded as worthy of clinical consideration when they persist beyond a time that is considered adaptive, estimated to be approximately 6 months by Prigerson, Frank, et al. (1995).

3.4. Expert consensus

Prigerson, Shear, et al. (1999) described the three-step procedure by which the consensus panel developed diagnostic criteria for CG. First, the panel of experts reviewed studies related to CG to determine how to best distinguish between normal and pathological grief. At that time, they agreed that a set of certain symptoms that persisted for more than 2 months would be an appropriate marker of dysfunction. Although there was evidence that grief symptoms assessed 6 months postloss were more predictive of long-term complications than those assessed at 2 months, members of the panel agreed that it would be unethical to allow individuals to suffer for 6 months before they qualified for a diagnosis. The 2-month duration criterion was agreed upon in accordance with the *DSM-IV* (1994) allowance for a major depressive episode (MDE) diagnosis if depressive symptoms endure for 2 months after bereavement. The panel also agreed to limit the precipitating event to death of a significant other in the initial stages of CG criteria development. The symptoms chosen for the preliminary evaluation were those related to prolonged functional impairment. Items to assess CG symptoms were extracted from existing psychopathology and grief symptom inventories (Frank, Prigerson, Shear, & Reynolds, 1997).

In the second step of criteria development, the panel chose to test empirically symptoms of both separation and traumatic distress using data from Zisook and Schuchter's (1991) widowhood study at the University of California, San Diego (Prigerson, Shear, et al., 1999). They conducted receiver operating characteristic (ROC) analyses on each item of a questionnaire that reflected all but one of their proposed symptom criteria. Each item was evaluated to determine its ability to identify individuals who were considered to have a true case of CG. Because there was no preexisting "gold standard" for diagnosis, those with scores in the upper 20% of the distribution were considered as positive cases of CG. This upper quintile was chosen because it has been demonstrated as a threshold for which individuals are at risk for dysfunction (Prigerson, Frank, et al., 1995; Prigerson, Maciejewski, et al., 1995). The panel prioritized the sensitivity of the symptom criteria over its specificity to increase the probability of capturing individuals who may have a diagnosis of CG. Still, they additionally gave consideration to the specificity of each item to aid in the distinction between normal and pathological grief.

In the third step, the team refined the criteria by removing two items that were poor indicators of true CG cases and then conducted the analyses again (Prigerson, Shear, et al., 1999). They found that the internal consistency coefficient of the symptom set increased from 0.77 to 0.81. The optimal sensitivity and specificity achieved was 0.93 and 0.93, respectively. They concluded that the most appropriate way to characterize "normal" grief reactions might be by noting an absence of the specified levels of symptoms in the proposed criteria.

Establishment of diagnostic criteria for the *DSM* typically relies on expert consensus. Although aspects of this process are subjective, utilization of procedures like the Delphi method (Kennedy, 2004)

and the Robins and Guze (1970) criteria for establishing diagnostic validity in mental disorders permit experts to evaluate objective evidence (e.g., results of signal detection and factor analyses) to determine the validity of diagnostic categories and to answer taxonic questions (Meehl, 2004). Jacobs, Mazure, and Prigerson (2000) expressed that the similarities between the Horowitz et al. (1997) and consensus panel (Prigerson, Shear, et al., 1999) diagnostic criteria of CG are "impressive" and provide "encouraging validation of the process of developing criteria" (p. 192) given that these criteria were independently derived. Unless other diagnostic criteria are specified, studies discussed throughout the remainder of this paper have assessed CG either categorically according to the diagnostic criteria established by the expert panel (Prigerson, Shear, et al., 1999) or dimensionally through use of the ICG (Prigerson, Maciejewski, et al., 1995).

4. Making the distinction: why is CG not PTSD?

From approximately 1997 to 2001, the symptoms of CG were referred to as traumatic grief because they reflect symptoms of both separation distress and traumatic distress (Chen et al., 1999; Prigerson, Bierhals, et al., 1997). The traumatic distress component was frequently conceptualized as "PTSD-like" by researchers because it included symptoms of reexperiencing (intrusive thoughts about the deceased), avoidance (avoidance of reminders about the deceased), and numbness (emotional numbness since death; Prigerson, Maciejewski, et al., 1995). In addition, similar to symptoms of PTSD, symptoms of CG may be effectively treated with selective serotonin reuptake inhibitors (Zygmont et al., 1998).

However, Marwit (1996) argued that sharing common features does not permit equating CG with other diagnostic entities like PTSD. Etiology, course, prognosis, and treatment must all be considered. Others have also asserted that PTSD and CG are not isomorphic (Enright & Marwit, 2002; Prigerson, Shear, et al., 1999). Although the traumatic distress symptoms of CG appear to resemble some of the symptoms of PTSD, the separation distress component is unique. To make the distinction clear, many investigators are abandoning the term, traumatic grief, and instead using CG.

4.1. Distinct precipitating events

Part of the etiologies of both CG and PTSD involves their respective precipitating events. Therefore, one of the fundamental questions that must be answered to determine if there is a distinction between these pathological states is: Are the precipitating phenomena (i.e., trauma and bereavement) inherently different? The distinction between CG and PTSD is blurred because of the overlap between loss and trauma that occurs in the real world (Raphael, 1997; Raphael & Martinek, 1997; Stroebe et al., 2001). Clearly, PTSD, as it is defined in *DSM-IV-TR* (2000), and CG can have common precipitating events when the death of a family member is the result of violent acts or circumstances (Raphael & Martinek, 1997). However, the criterion stating that the response to the PTSD stressor must involve fear, helplessness, or horror is subjective (American Psychiatric Association, 2000). In addition, it may be difficult to categorize unpleasant deaths as nontraumatic (Raphael & Martinek, 1997).

Typically, reactions to bereavement do not involve fear or horror, although they may involve feelings of helplessness (Prigerson et al., 2000). Intensity of the impact of bereavement is related to the relationship of the bereaved to the deceased, whereas the impact of trauma is related to the

enormity of the stressor event. CG may not yet have entered the current nosology of mental disorders because the traumatic events that precipitate PTSD are thought of as beyond the scope of normal experiences, whereas the precipitating event for CG is perceived as a universal experience (Horowitz, Bonanno, & Holen, 1993; Stroebe et al., 2001). It is important to note, however, that although the experience of bereavement is universal, the symptoms of CG and their requisite severity and persistence are not.

4.2. Distinct phenomenology

Stroebe et al. (2001) discussed some of the differences between the phenomenology of PTSD and grief reactions, including CG. As discussed above, the actual events of the trauma impact a trauma survivor, whereas the loss of the bond to the deceased affects a grieving individual. The forms of anxiety that traumatized and bereaved individuals experience are also distinctive. Traumatized individuals are typically anxious about the threat related to the traumatic event, whereas bereaved individuals experience separation anxiety. The authors observed that, in general, anxiety plays a less significant role for the bereaved than it does among trauma victims. Sadness tends to occur more frequently among the bereaved than among those who have been traumatized. Furthermore, grieving individuals uniquely experience yearning and pining. Coping efforts typically involve reorienting oneself in the world without the deceased rather than processing the events of the death, as might occur following a traumatic stressor (Stroebe et al., 2001). Marwit (1991) also noted some important distinctions. First, one's personal sense of safety is frequently challenged after a trauma, but not necessarily following bereavement. Second, there is always an impact on the primary relationship network after bereavement, but such an impact is not common following a trauma.

As mentioned earlier, the three diagnostic symptom categories of PTSD, namely, reexperiencing, avoidance, and increased arousal, appear to characterize many of the symptoms of CG. Further scrutiny demonstrates, however, that the symptom content of these two disorders is quite dissimilar. The intrusive thoughts characteristic of reexperiencing in PTSD are qualitatively different from those experienced in CG (Raphael & Martinek, 1997; Stroebe et al., 2001). PTSD intrusions involve memories of the traumatic event and experiencing related emotions, whereas CG intrusions are typically images of the deceased (Raphael & Martinek, 1997). In PTSD, intrusions involve uncontrollable activation of memories of the traumatic event that are negative and distressing (Horowitz, Bonanno, & Holen, 1993). Intrusions experienced by individuals with CG, on the other hand, are typically positive and comforting (Horowitz, Bonanno, & Holen, 1993; Prigerson & Jacobs, 2001a). Horowitz, Bonanno, & Holen (1993) explained how these soothing thoughts and this temporary period of consolation may be contrasted with the stark reality of the deceased's absence and impossibility of such positive experiences occurring with their loved one ever again, resulting in what they call a "trauma of contrast" (p. 270). In fact, PTSD and CG are further distinguished because of the tendency of some grieving individuals to treasure and permit these positive memories to remain in their consciousness, often to the extent that they are maladaptive and prohibit them from moving forward (Horowitz, Bonanno, & Holen, 1993).

Stroebe et al. (2001) also remarked that traumatized individuals more frequently avoid reminders of the event, whereas the bereaved might seek them out. Other researchers have noted dissimilarities in the nature of avoidance among sufferers of PTSD versus CG as well. Individuals with CG do not appear to avoid reminders of threat as individuals with PTSD often do, but rather avoid reminders of the absence

of the deceased through denial and dissociation (Prigerson & Jacobs, 2001a; Prigerson, Jacobs, Rosenheck, & Maciejewski, 1999). In fact, they tend to seek out reminders of the deceased's presence. They are also more likely to speak with others about the loss, whereas individuals with PTSD frequently withdraw socially (Stroebe et al., 2001).

Despite Horowitz et al.'s (1997) proposal that avoidance is a core symptom of CG, it may not be common among symptomatic individuals (Prigerson & Jacobs, 2001a; Spooren, Henderick, & Jannes, 2000/2001). Prigerson and Jacobs (2001a) highlighted the low sensitivity (.26) of the avoidance item at the 14-month postloss assessment in the Horowitz et al. study. In addition, the avoidance item in the preliminary version of the ICG had low specificity in predicting cases of CG (Prigerson, Maciejewski, et al., 1995). In fact, because of its low specificity and because its removal improved the internal consistency of the traumatic distress criterion of the ICG, Prigerson, Maciejewski, et al. (1995) deleted avoidance from the original symptom set (Prigerson & Jacobs, 2001a; Prigerson, Shear, et al., 1999). Hence, it appears that avoidance is not a fundamental symptom in CG as it is in PTSD phenomenology.

Prigerson, Maciejewski, et al. (1995), Prigerson, Shear, et al. (1999), and Prigerson and Jacobs, (2001a) also observed that hypervigilance had low specificity in diagnosing cases of CG. They found that the role of hypervigilance in CG was limited to searching for cues or reminders of the deceased, whereas a reaction to threatened safety is highly prevalent among individuals with PTSD. Therefore, it appears that although avoidance and hypervigilance are signature symptoms of PTSD, they are poor markers of CG. Broadly speaking, the "trauma" in bereavement following a natural death involves separation, rather than an extreme and unusual event (Prigerson & Jacobs, 2001a). The resulting symptoms of separation distress, as opposed to fear of a threatening event, distinguish CG from PTSD.

4.3. Distinct theories of etiology and risk factors

There also appear to be unique risk factors associated with the onset of CG. In assessing both grief and posttraumatic stress symptoms among children who were victims of a sniper attack, Pynoos et al. (1987) found that higher grief symptom levels, as assessed by the Grief Reaction Inventory developed for their study, were associated with how close the child was to the deceased schoolmate; whereas higher levels of PTSD symptoms were correlated with severity of threat on the surviving child's life. Silverman et al. (2001) observed that widowed individuals who reported childhood adversities (e.g., abuse or parental loss) were at increased risk for developing CG, whereas those who reported adult traumas (e.g., nonbereavement traumatic event or loss of a child) were more likely to develop PTSD.

Silverman et al. (2001) proposed theories of etiology that further distinguished CG and PTSD. They postulated that the distinctive risk factors they observed might be explained by the increased risk of developing insecure attachment styles (see Bowlby, 1963) following adverse childhood events, such as parental loss. Insecure attachments may increase an individual's vulnerability to separation distress, and therefore CG, later on in life. Because adult attachment styles are believed to be more fixed, challenges later in life (e.g., the loss of a child) may not have as great an impact on relationship security, but rather increase risk for traumatization and the development of PTSD. Silverman et al. (2001) alternatively hypothesized that children who experience adversity are likely to endure numerous other challenging circumstances, leaving them more vulnerable to long-term psychosocial problems and psychiatric disorders. These individuals may react differently when faced with traumatic stressors than those who experience adversity solely in adulthood and do not have additional stressful life circumstances.

4.4. Distinct clinical correlates

Both the *DSM-IV-TR* (2000) criteria for PTSD and the Horowitz et al. (1997) criteria for CG include sleep disturbances as a symptom (Prigerson & Jacobs, 2001a). McDermott et al. (1997) examined electroencephalographic (EEG) sleep variables among sufferers of CG (as assessed by a proxy score of the ICG) to determine whether sleep fragmentation and increased REM sleep intensity, which have been found among those with PTSD, occurred within their sample. Because intrusive thoughts are characteristic of both disorders, they speculated that sleep disturbances would occur among individuals with CG as they do among those with PTSD. Individuals with CG who did not have comorbid depression displayed relatively normal EEG sleep profiles. Thus, the authors did not find the same pattern of sleep continuity impairment among patients with CG as has been found among those with PTSD (McDermott et al., 1997).

4.5. Distinct courses and outcomes

Recovery from CG involves reconstructing life without a loved one, whereas individuals with PTSD focus on reestablishing safety in the world (Marwit, 1996). Because efforts to distinguish CG and PTSD have only gained attention more recently, there is little empirical support available on their course and outcome differences.

4.6. Distinct responses to assessment and interventions

Without establishment of standardized criteria reflecting the unique phenomena of CG, might some individuals be overlooked during assessment? Empirical evidence demonstrates that the answer is yes. Researchers have found little agreement between diagnoses of PTSD and CG (Prigerson & Jacobs, 2001a; Prigerson, Jacobs, et al., 1999; Prigerson, Shear, et al., 1999). For example, Silverman et al. (2001) found that 18% met criteria for a diagnosis of CG and 7% met criteria for PTSD in their study of 85 conjugally bereaved individuals. In addition, CG displayed the lowest comorbidity rate when compared to both MDD and PTSD. Forty percent of those with CG solely met criteria for CG (compared to 20% for MDD and 0% for PTSD), and CG was the most prevalent of these three diagnoses among the widowed sample. See Table 1 for additional examples. If the individuals in these studies had been assessed exclusively for PTSD, the majority of them would not have received a diagnosis and consequently may not have received the appropriate clinical attention that they needed.

Individuals with CG and PTSD appear to have distinct responses to treatment interventions as well. In working with survivors of the Beverly Hills Supper Club fire, Lindy, Green, Grace & Titchener (1983) asserted that traumatic stress reactions needed to be addressed first to facilitate work with issues of bereavement. Although both grief and trauma challenge assumptions about the world (Janoff-Bulman, 1992; Neimeyer, Prigerson, & Davies, 2002), they require different forms of adaptation to recover (Raphael & Martinek, 1997). This, in addition to the distinct etiologies identified by Silverman et al. (2001) above, suggests that individuals with CG have unique treatment needs that differ from the needs of those with PTSD. Individuals with CG need to resolve attachment issues, whereas individuals with PTSD must emotionally habituate to fearful responses. Although prolonged exposure appeared efficacious in reducing symptoms of CG in a pilot study (Shear et al., 2001), anecdotal evidence suggests that the level of distress that it provokes is frequently difficult for patients to tolerate. Sufferers

of CG may respond better to focusing of the meaning of the loss or more integrative psychotherapeutic approaches that involve both exposure and meaning-making strategies (Neimeyer, 2000, 2001; Neimeyer et al., 2002).

5. Making the distinction: why is CG not MDD?

The experience of grief often involves depressive symptoms (Clayton, 1982). Not surprisingly, early research efforts in the field of bereavement focused on depression (Prigerson, Frank, et al., 1995; Zisook & Devaul, 1983). According to the *DSM-IV-TR* (2000), bereaved individuals can receive an MDD diagnosis if they meet criteria at least 2 months after the death of an intimate, or have specific symptoms like "marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation" (p. 356). Researchers have found, however, that there is a different pattern of symptoms, indicative of CG, which is predictive of long-term dysfunction (Prigerson, 2002). MDD does not adequately describe the symptom phenomenology of CG (Horowitz et al., 1997).

5.1. Distinct phenomenology

Distinguishing CG and MDD has been difficult because of the expectation that they may coexist following bereavement (Prigerson, Frank, et al., 1995). Despite their potential cooccurrence, their symptom profiles are distinct (Enright & Marwit, 2002; Horowitz et al., 1997; Prigerson & Jacobs, 2001a). As discussed above, Prigerson, Frank, et al. (1995) empirically demonstrated that CG was distinct from MDD by conducting a principal components analysis on a variety of grief-related symptoms and found that two factors emerged: one considered bereavement-related depression and the other characterized by the specific symptoms of CG. The only two symptoms that loaded onto both Factors 1 and 2 were loneliness and lack of acceptance of the death, but the researchers grouped these symptoms into the cluster onto which they loaded most highly (bereavement-related depression and CG, respectively). The findings of this study were replicated in additional samples (refer to Table 1 for studies demonstrating the distinct phenomenology of CG). In developing diagnostic criteria for CG, Horowitz et al. (1997) similarly distinguished the intrusion, avoidance, and failure to adapt symptoms characteristic of CG from symptoms of MDD, observing that CG and MDD symptoms frequently did not overlap.

5.2. Distinct risk factors

To explore risk factors of CG, van Doorn, Kasl, Beery, Jacobs, & Prigerson (1998) examined individuals caring for their terminally ill spouses prior to and following their spouses' death. They demonstrated that a close, security-enhancing relationship with the significant other, which had been implicated in prior reports (Prigerson, Shear, Bierhals, et al., 1997; Prigerson, Shear, Frank & Beery, 1997), predicted CG symptoms. Insecure attachment styles, including excessive dependency, compulsive caregiving, and defensive separation, were also related to CG. After examining various multiple regression models, they found that the model that best explained CG symptoms included both a security-enhancing marriage and an insecure attachment style as predictors. The authors reasoned that

these marriages served to meet attachment needs that would have been otherwise unfulfilled for individuals with insecure attachment styles (van Doorn et al., 1998). Although these risk factors and models predicted CG, none of them was associated with symptoms of depression.

5.3. Distinct clinical correlates

The associated features of CG are also different than those of bereavement-related depression (Enright & Marwit, 2002; Prigerson & Jacobs, 2001a). In their study of EEG sleep variables, McDermott et al. (1997) distinguished CG from bereavement-related depression among late-life conjugally bereaved individuals. The main effects of depressive symptoms on polysomnographic measures, such as sleep efficiency and maintenance, were not found for any of the effects of CG symptoms on the EEG sleep variables studied.

Bereaved individuals also appear to have a unique response to the Dexamethasone Suppression Test (DST; Schuchter, Zisook, Kirkorowicz, & Risch, 1986). Cortisol levels normally decrease in response to the administration of dexamethasone, a synthetic compound similar to cortisol, and therefore abnormal responses to the DST may indicate overproduction of cortisol in the body. Failure to suppress when given the DST has been associated with depressive symptoms (Goodkin et al., 2001). However, Schuchter et al. (1986) found that rates of nonsuppression to the DST were associated with the severity of anxiety rather than to the severity of depression among bereaved individuals. In addition, Jacobs (1987) reported that symptoms of acute separation distress, a core component of CG, were related to increases in urinary free cortisol and plasma growth hormone among widowed individuals. However, depressive symptoms were not associated with these clinical markers in this study sample (Jacobs, 1987).

5.4. Distinct courses and outcomes

The course of bereavement-related depression also may be different from the course of CG (Pasternak et al., 1991, 1993; Prigerson, Bierhals et al., 1996; Prigerson, Frank, et al., 1995; Zisook & Devaul, 1983). Pasternak et al. (1993) found that grief did not resolve as quickly or as distinctly as depression in their study of elderly conjugally bereaved individuals. Depressive and grief symptoms were evaluated over a period of 18 months. Although depressive symptoms appeared to remit as is typical in the course of depression, grief symptoms assessed by the Texas Revised Inventory of Grief (TRIG; Faschingbauer, Zisook, & DeVaul, 1987) remained more severe and stable over time (Pasternak et al., 1993). Prigerson, Frank, et al. (1995) similarly found that bereavement-related depression decreased over time significantly more among participants who were treated with nortriptyline for depression than for nontreated participants, but that there were no differences between the treated and nontreated participants in CG over time.

5.5. Distinct responses to assessment and interventions

Assessment of depressive and CG symptoms has revealed that although they are frequently comorbid, they can occur independently (Enright & Marwit, 2002; Horowitz, Bonanno, & Holen, 1993; Prigerson, Shear, et al., 1997). Prigerson, Frank, et al. (1995) reported, for example, that 46% of individuals diagnosed with CG did not meet criteria for MDD. Additional examples are presented in Table 1. These findings suggest that CG is a distinct entity not fully accounted for in assessing for existing mental disorders.

Another key distinguishing factor between bereavement-related depression and CG is their independent responses to treatments. Prior studies have found that grief symptoms (as assessed by the TRIG) were not reduced through treatment with tricyclic antidepressants, suggesting they are distinctive from depressive symptoms and require a different type of intervention (Jacobs & Lieberman, 1987; Pasternak et al., 1991). Reynolds et al. (1999) conducted post hoc analyses of a placebo-controlled trial comparing nortriptyline, interpersonal therapy (IPT), and their combination to treat bereavement-related depression. CG was assessed using the ICG, and for those individuals likely to have a CG diagnosis (scores>25), scores decreased approximately 20% over the 16-week study period. There were no effects on rates of decline due to IPT, nortriptyline, or a combination of the two. The antidepressant medication and the combination of medication plus IPT did, however, reduce depressive symptoms when compared to placebo. Individuals with bereavement-related depression responded to traditional treatments of MDD (i.e., a tricyclic antidepressant and IPT), whereas individuals with CG appeared to need a different approach to alleviate their suffering (Frank et al., 1997; Prigerson, Bierhals, et al., 1996; Prigerson & Jacobs, 2001a).

6. Making the distinction: why is CG not AD?

According to the *DSM-IV-TR* (2000), Criterion A for diagnosing AD requires the "development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s)" (p. 683). Symptoms of CG could in essence be captured by this description. So why not use the AD criteria to diagnose individuals who present with clinically significant symptoms that cause marked distress or functional impairment following bereavement?

One of the most obvious rebuttals to this position is that Criterion D of the diagnostic criteria for AD states that the symptoms cannot be a consequence of bereavement, therefore prohibiting this diagnosis (American Psychiatric Association, 2000; Enright & Marwit, 2002; Prigerson & Jacobs, 2001a). In addition, there is empirical evidence demonstrating CG is composed of specific clinical symptoms (e.g., Prigerson, Frank, et al., 1995; see Table 1), rendering the broad description of AD inexact (Prigerson & Jacobs, 2001a). Horowitz et al. (1997) similarly argued that AD is not specific enough to adequately serve as the diagnosis for the symptoms of CG. Horowitz, Bonanno, and Holen (1993) contended that AD is a "time-limited and diffuse entity, inadequate to problems of either research or clinical work" (p. 271). The time limitation is too constraining because, as Enright and Marwit (2002) pointed out, symptoms of CG may begin after the 3-month window in which symptoms for AD must commence and may last beyond the 6-month cap by which time symptoms of AD must resolve (if the stressor is not chronic). Studies have demonstrated that the symptoms of CG may endure for years (refer to Table 1 for list), and thus, those who may be suffering the most could not receive a diagnosis if AD was the only alternative (Prigerson & Jacobs, 2001a).

7. Disadvantages of establishing CG as a diagnostic entity

There are several criticisms that must be addressed before CG is established as a mental disorder in the currently accepted nosology. A frequently cited point of opposition is that normal grief may be "pathologized" if CG is listed in standardized diagnostic manuals (Prigerson & Jacobs, 2001a,b; Stroebe

et al., 2001, 2000). Belitsky and Jacobs (1986) noted the "two-edged sword" (p. 279) of diagnosing pathological grief because of its existence on a continuum with normal grief. Appropriate identification can facilitate intervention and resolution, but one must be careful about pathologizing a normal human process and about iatrogenic effects. However, researchers have already offered prescriptions to prevent overpathologizing. For example, a 6-month duration criterion may help to distinguish individuals who are experiencing temporary distress from individuals with more chronic difficulties. In addition, Prigerson and Jacobs (2001a) emphasized the clinical presentation of normal grief may be best characterized as the absence of CG symptoms, and thus it is unlikely that normal grief symptoms would be misdiagnosed if specific standardized diagnostic criteria were instituted. Furthermore, Prigerson (personal communication, June 16, 2004) found that over 95% of the bereaved participants in the Yale Bereavement Study reported that they would be helped, and not hurt, by a CG diagnosis, and that the diagnosis would clarify what was bothering them to family members, friends, clinicians, and themselves.

Another argument against establishing a CG diagnosis in the *DSM* is that individual and cultural variability might make it difficult to determine when a reaction is pathological (Frank et al., 1997; Prigerson, Frank, et al., 1995). It may be difficult, but efforts to address such concerns have already begun (see Prigerson et al., 2002); and the same process to empirically derive and validate criteria for CG has been may be applied in even more diverse populations. Cultural variability is not an issue unique to CG, and therefore, it should be taken into consideration in assessment and diagnosis of all mental disorders.

Stroebe et al. (2000) considered other negative consequences of instituting CG as a mental disorder. It may result in increased costs to create interventions as more individuals with the disorder are detected. However, the costs of interventions are an issue for the treatment of all disorders and disregarding CG will not resolve it. In fact, because individuals are currently often misdiagnosed and do not receive insurance reimbursement, the establishment of CG in standard taxonomies may be more cost effective in the long run. An additional harmful consequence could be that informal social support networks are weakened because of the increased availability of the mental health profession. Increasing general awareness about the distinction between uncomplicated and CG reactions could prevent this type of negative impact.

Another risk of standardization is that subsequent refinement of the criteria would cease after the establishment of CG as a formal diagnosis (Stroebe et al., 2000). It is therefore essential that empirical validation that has been conducted thus far be replicated in more heterogeneous samples before such a decision is made. Stroebe et al. (2000) also argued that the establishment must be based on "the validity of the concept" (p. 72) rather than on the positive consequences of such an action. Throughout this paper, theoretical, clinical, and empirical evidence have been cited demonstrating that the concept of CG is valid.

8. Advantages of establishing CG as a diagnostic entity

8.1. Reduced mental health morbidity

It has been argued above that the symptoms of CG are distinct from those of existing disorders. Now, it is important to demonstrate why these symptoms deserve clinical attention. One of the primary reasons that standardized diagnostic criteria for CG should be developed is to facilitate prevention of the substantial amount of psychological and physical health problems that have been associated with its

symptoms. Bereavement in general, and pathological grief more specifically, has been linked to increased risk for the development of a number of psychiatric complications (Zisook, Schneider, & Schuchter, 1990; Zisook & Schuchter, 1991). Yet, it appears that individuals with CG are less likely to utilize mental health services than those diagnosed with MDE (Prigerson et al., 2001).

In their preliminary investigation of CG, Prigerson, Frank, et al. (1995) explored whether or not the factors resulting from their factor analysis were predictive of dysfunction 18 months postbereavement. While the bereavement-related depression factor was only predictive of medical illness at follow-up, the CG factor predicted poorer global functioning, depressed mood, decreased sleep quality, and low self-esteem at the 18-month assessment. CG more strongly predicted long-term difficulties among individuals who were initially assessed between 3 and 6 months postloss (as opposed to between 0 and 3 months). This is the primary reason that the 6-month duration criterion for CG has been established. The authors commented that their sample might have been biased because of the exclusion of individuals with severe medical illness or a history of psychopathology. Because the excluded individuals may have in fact been at even greater risk for developing CG, associations that might have been found among a more vulnerable population may have been reduced. Other studies have demonstrated that CG is associated with quality of life impairments in numerous domains, including mental health and social functioning (Prigerson, Maciejewski, et al., 1995; Silverman et al., 2000). Furthermore, a CG diagnosis better predicted these impairments than either a diagnosis of PTSD or MDE (Silverman et al., 2000). Horowitz, Bonanno & Holen (1993) posited that prolonged grief reactions might impact social functioning through the stigma of loss, by negatively affecting existing support networks, or by impairing the resumption of social roles. See Table 1 for studies indicating the association between CG and poorer mental health and quality of life.

CG also critically warrants clinical attention because of its association with increased risk of suicide and suicidal ideation (Stroebe & Stroebe, 1993). Szanto, Prigerson, Houck, Ehrenpreis, and Reynolds (1997) examined a separate sample of widowed elderly individuals that included some patients who were participating in a treatment outcome study for bereavement-related depression. After assessing CG dimensionally in this sample, they found that higher levels of CG symptoms at baseline were predictive of and coexisted with suicidal ideation during treatment over and above symptoms of depression, anxiety, hopelessness, and lack of social support. Fifty-seven percent of patients with high levels of CG reported suicidal ideation, as compared to only 24% of the patients with low ICG scores (Szanto et al., 1997). They also found that active ideators (those who were planning to commit suicide) had significantly higher CG scores (in the upper 20% of the ICG score distribution) than passive ideators (those who may have wanted to die, but indicated they would not commit suicide). Active ideators reported higher levels of CG than passive ideators during periods of suicidal ideation, even when controlling for depressive symptoms. More studies demonstrating the relationship between CG and suicidality are presented in Table 1. These studies suggest that CG is a useful clinical indicator of active suicidal ideation risk over and above other mental disorders.

8.2. Reduced physical health morbidity

CG symptoms have also been related to a number of specific physical health consequences. Prigerson, Bierhals, et al. (1997) found that high levels of CG at 6 months postloss predicted negative health changes at 13 and 25 months postloss among mid- to late-life widows and widowers. CG symptoms were associated with high systolic blood pressure, heart trouble, cancer, changes in eating and smoking

habits, and sleep problems at either 13 or 25 months postloss when controlling for age, sex, prior pathology, and high levels of depression and anxiety. In addition, individuals with CG had significantly higher rates of heart trouble, cancer, headaches, and the flu around the anniversary of the death than those without CG (Prigerson, Bierhals, et al., 1997).

Chen et al. (1999) reported that there were gender differences in physical health outcomes for conjugally bereaved men and women. Among widowers, high levels of CG at 13 months predicted hospitalization, having a physical health event, and having an accident; and at 25 months, they predicted high blood pressure. Among widows, CG symptoms predicted sleep changes around the anniversary of the death at 13 months; and heart trouble, having a physical health event, and changes in eating habits at 25 months. The greatest impact of CG appeared to be among men at 13 months. Because other types of physical and mental morbidity were predicted by bereavement-related depression and anxiety, this study suggested that these symptom clusters should be considered in conjunction with CG when determining the full impact of bereavement (refer to Table 1 for additional investigations of independent physical health outcomes).

8.3. Improvement in assessment of CG

A primary benefit of establishing standardized diagnostic criteria for CG would be the development of empirically validated measures of its symptoms. Assessment tools could aid in research evaluating the risk factors, consequences, and treatment of CG. Until recently, measures of grief included both normal and pathological symptoms. They were therefore considered overinclusive with respect to symptoms of normal grief and underinclusive with respect to symptoms of CG (Prigerson, Maciejewski, et al., 1995; Prigerson, Shear, et al., 1997).

To remedy this problem, Prigerson, Maciejewski, et al. (1995) developed the ICG to assess CG symptoms after demonstrating that there was a cluster of grief symptoms distinct from symptoms of bereavement-related depression and anxiety that were predictive of long-term functional impairment. The 19-item measure assessed the frequency (i.e., never, rarely, sometimes, often, or always) with which the respondent experienced these symptoms at the time of the assessment, and the researchers have demonstrated its reliability. Although the ICG was highly correlated with the TRIG ($r=.87$, $p<.01$), the ICG better assessed CG (as opposed to grief in general) because it was able to identify individuals suffering from a greater scope of functional impairments more precisely than the TRIG.

8.4. Improvement in treatment of CG

Arriving at a consensus about diagnostic criteria would also facilitate the development of appropriate specific interventions for individuals with CG. Several prescriptions for psychotherapeutic treatments have been proposed, and some of these have been empirically evaluated. However, the general paucity of established effective techniques or process research can be attributed to the deficiency in a diagnostic standard. This is an especially critical issue in grief therapy efficacy research because symptoms associated with normal grief dissipate over time yielding smaller treatment effects and because of the generally low statistical power of treatment outcome studies due to small sample sizes (Allumbaugh & Hoyt, 1999).

While a large effect size of .8 was found in a meta-analysis of treatments for depression (Robinson, Berman, & Neimeyer, 1990), a small effect size of .13 was found in a meta-analysis of 23 bereavement interventions (Cohen, 1988; Fortner & Neimeyer, 1999). However, the effect size increased to .39 when Fortner and Neimeyer (1999) focused their meta-analysis only on the five bereavement interventions that

targeted individuals who had or were at risk for developing CG. This finding supports the need to develop standardized diagnostic criteria for CG so that individuals who will benefit most from intervention, as opposed to the majority of individuals who will resolve their grief normally, can be accurately identified and treated accordingly. Because of their lack of efficacy and perhaps even potential for harm among individuals who are grieving normally, psychosocial interventions for the bereaved may only be appropriate for those with pathological grief (Bonanno, 2004).

If diagnostic criteria are established, researchers will be able to conduct controlled studies of CG and further our scientific understanding of its phenomenology and underlying risk factors. This will help resolve questions about which symptoms should be targeted, thus leading to the development of more effective treatments (Marwit, 1996). For example, after finding risk factors associated with CG were distinct from those related to PTSD, Silverman et al. (2001) recommended that interventions for CG focus on issues of separation anxiety that may have arisen because of adversities in childhood rather than on emotional processing, which is better suited to treat PTSD. In addition, although some studies have demonstrated a reduction in symptoms of avoidance (Horowitz et al., 1984; Mawson, Marks, Ramm, & Stern, 1981), Prigerson, Shear, et al. (1999) found low levels of avoidance among individuals diagnosed with CG and that it was also a poor indicator of CG. Thus, treatments that focus on reducing symptoms of avoidance may not be the most efficient at treating all cases of CG.

8.5. Additional benefits

Prigerson, Frank, et al. (1995) discussed additional benefits, including preventing costs of not treating this disorder (e.g., long-term dysfunction) and stimulating further research on CG. The provision of an appropriate diagnosis is not only necessary to individualize treatment plans, but also because of the realistic difficulties that patients have obtaining insurance coverage (Marwit, 1991; Prigerson, Frank, et al., 1995). Bereavement is currently coded as a "V" category on Axis I and therefore does not qualify for insurance coverage.

Because there are no diagnostic criteria for CG, studies assessing the bereaved focus on MDD and neglect or underestimate other problems (Horowitz et al., 1997; Stroebe et al., 2000). This is especially problematic because research suggests that CG might be the most prevalent psychopathological response to a bereavement event, far exceeding the prevalence of MDD or PTSD (Silverman et al., 2001). Silverman et al. (2000) found that 37.5% of widows and widowers who met criteria for CG did not meet criteria for PTSD nor MDE, suggesting that it is a unique entity that would be neglected in the assessment for existing mental disorders.

There is both clinical and research utility in the establishment of CG as a diagnostic entity. As with all diagnostic criteria, it can aid in assessment and in communication among clinicians, as well as provide comfort to patients who do not understand why they cannot cope adequately with a loss. It also would permit mental health professionals to focus resources and interventions on those in greatest need (Sanders, 1993; Stroebe et al., 2000).

9. Research limitations and future directions

There are numerous limitations in the research that must be addressed. Schlernitzauer et al. (1998) discussed the obstacles that arise in recruitment for bereavement studies. Study samples may not be

representative because different recruitment methods yield different rates of participation and homogenous study samples. Stroebe et al. (2000) argued that cultural and societal differences must be explored and taken into consideration. In addition, most studies have recruited mid- to late-life participants because that is when spousal bereavement is most common. Future studies should target younger populations, including children, and explore other demographic differences (Prigerson, Shear, et al., 1999). Recruitment problems might be remedied by the use of referrals from healthcare providers (Schlernitzauer et al., 1998).

It is likewise important to investigate further the duration criteria proposed, to determine whether or not there are subtypes of CG, and to explore different precipitating events (e.g., divorce) that might lead to the development of CG (Prigerson, Shear, et al., 1999). Stroebe et al. (2001) additionally argued that further differentiation between CG and PTSD is necessary before a new *DSM* category is created. They suggested that reactions to nontraumatic bereavements be considered separately and not necessarily subsumed by the CG diagnosis proposed by Prigerson, Shear, et al. (1999) unless it is suggested by empirical evidence. Risk factors for CG also need to be further explored (Prigerson, Shear, et al., 1999). For example, the role of personal meaning in the nature of the loss and relationship with the deceased might be better defined by the survivor rather than researchers using objective measures of the nature, impact, and level of preparedness of the loss (Barry, Kasl, & Prigerson, 2002; Prigerson, Shear, et al., 1999; Stroebe et al., 2001). There may also be protective factors that diminish one's risk for developing CG, such as a secure attachment style (Beery et al., 1997).

10. Conclusion

We have argued that the existing diagnostic categories of the *DSM-IV-TR* (2000) fail to adequately meet the needs of individuals experiencing pathological reactions to bereavement. The symptoms, risk factors, clinical correlates, and responses to interventions are distinct from those of PTSD, MDD, or AD. Furthermore, CG symptoms are associated with enduring psychological and physical dysfunction. Interventions for CG also require specific assessment instruments and treatments to identify effectively the disorder and reduce symptoms. Although consideration must be given to the costs of establishing CG as a distinct diagnostic entity, it is clear that the advantages outweigh the disadvantages. Prigerson and Jacobs (2001a) summarized this perspective by asserting that "...the harm done by not diagnosing those at risk (false negatives) is, in our view, a greater concern than the misdiagnosis of those who are grieving normally" (p. 621).

Throughout this paper, solid research evidence has demonstrated that CG is associated with distress, impairment in functioning, and deviates from expected and culturally sanctioned grief reactions. Based on this evidence, it deserves a place in the standardized diagnostic manuals. The American Psychiatric Association (2000) does not expect to publish *DSM-V* until at least 12 years from the publication of *DSM-IV-TR*. We have, therefore, a window of opportunity. During this time, research endeavors should continue to refine diagnostic criteria in preparation for inclusion in the nosology of mental disorders.

Managed care constraints necessitate the focus of clinical attention on those individuals in greatest need. As mentioned above, the benefits of standardizing diagnostic criteria for CG include helping clinicians to detect and effectively treat these symptoms, and aiding researchers in assessing prevalence, risk factors, neurobiology, outcomes, and preventive interventions (Prigerson, Shear, et al., 1999). Now, more than ever, as the "baby boomers" age and the frequency of loss increases, this movement is imperative.

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References

Allumbaugh, D. L., & Hoyt, W. T. (1999). Effectiveness of grief therapy: A meta-analysis. *Journal of Counseling Psychology, 46*, 370–380.

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders. (3rd ed., Revised). Washington, DC: Author.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders. (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders. (4th ed., Text Revision). Washington, DC: Author.

Barry, L. C., Kasl, S. V., & Prigerson, H. G. (2002). Psychiatric disorders among bereaved persons: The role of perceived circumstances of death and preparedness for death. *American Journal of Geriatric Psychiatry, 10*, 447–457.

Beery, L. C., Prigerson, H. G., Bierhals, A. J., Santucci, L. M., Newsom, J. T., Maciejewski, P. K., et al. (1997). Traumatic grief, depression and caregiving in elderly spouses of the terminally ill. *Omega-Journal of Death & Dying, 35*, 261–279.

Belitsky, R., & Jacobs, S. (1986). Bereavement, attachment theory, and mental disorders. *Psychiatric Annals, 16*, 276–280.

Bierhals, A. J., Prigerson, H. G., Fasiczka, A., Frank, E., Miller, M., & Reynolds, C. F., III (1995–1996). Gender differences in complicated grief among the elderly. *Omega: Journal of Death & Dying, 32*, 303–317.

Boelen, P. A., van den Bout, J., & de Keijser, J. (2003). Traumatic grief as a disorder distinct from bereavement-related depression and anxiety: A replication study with bereaved mental health care patients. *American Journal of Psychiatry, 160*, 1339–1341.

Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, 20–28.

Bowlby, J. (1963). Pathological mourning and childhood mourning. *Journal of the American Psychoanalytic Association, 11*, 500–541.

Bowlby, J. (1980). *Attachment and loss. Vol. 3. Loss: Sadness and depression*. New York: Basic Books.

Carr, D., House, J. S., Kessler, R. C., Nesse, R. M., Sonnega, J., & Wortman, C. (2000). Marital quality and psychological adjustment to widowhood among older adults: A longitudinal analysis. *Journals of Gerontology: Social Sciences, 55B*, S197–S207.

Chen, J. H., Bierhals, A. J., Prigerson, H. G., Kasl, S. V., Mazure, C. M., & Jacobs, S. (1999). Gender differences in the effects of bereavement-related psychological distress in health outcomes. *Psychological Medicine, 29*, 367–380.

Clayton, P. (1982). Bereavement. In E. Paykel (Ed.), *Handbook of affective disorders* (pp. 403–415). New York: Guilford Press.

Cohen, J. (1988). Statistical power analysis for the behavioral sciences. (2nd ed.). Hillsdale, NJ: Erlbaum.

Engle, G. L. (1961). Is grief a disease? A challenge for medical research. *Psychosomatic Medicine, 23*, 18–22.

Enright, B. P., & Marwit, S. J. (2002). Diagnosing complicated grief: A closer look. *Journal of Clinical Psychology, 58*, 747–757.

Faschingbauer, T. R., Zisook, S., & DeVaul, R. (1987). The Texas Revised Inventory of Grief. In S. Zisook (Ed.), *Biopsychosocial aspects of bereavement* (pp. 109–124). Washington, DC: American Psychiatric Association Press.

Figley, C. R., Bride, B. E., & Mazza, N. (Eds.). (1997). *Death and trauma: The traumatology of grieving*. Washington, DC: Taylor & Francis.

Fortner, B., & Neimeyer, R. A. (1999). The effectiveness of grief counseling and therapy: A quantitative review. *Death Studies, 23*, 387–411.

Frank, E., Prigerson, H. G., Shear, M. K., & Reynolds, C. F., III (1997). Phenomenology and treatment of bereavement related distress in the elderly. *International Clinical Psychopharmacology, 12*, S25–S29.

Goodkin, K., Baldewicz, T. T., Blaney, N. T., Asthana, D., Kumar, M., Shapshak, P., et al. (2001). Physiological effects of bereavement and bereavement support group interventions. In M. S. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 671–703). Washington, DC: American Psychological Association.

Green, B. (2000). Traumatic loss: Conceptual and empirical links between trauma and bereavement. *Journal of Personal and Interpersonal Loss, 5*, 1–17.

Horowitz, M. J., Bonanno, G. A., & Holen, A. (1993). Pathological grief: Diagnosis and explanation. *Psychosomatic Medicine, 55*, 260–273.

Horowitz, M. J., Marmar, C., Weiss, D. S., DeWitt, K. N., & Rosenbaum, R. (1984). Brief psychotherapy of bereavement reactions: The relationship of process to outcome. *Archives of General Psychiatry, 41*, 438–448.

Horowitz, M. J., Siegel, B., Holen, A., Bonanno, G. A., Milbrath, C., & Stinson, C. H. (1997). Diagnostic criteria for complicated grief disorder. *American Journal of Psychiatry, 154*, 904–910.

Horowitz, M. J., Stinson, C. H., Fridhandler, B., Milbrath, C., Redington, D., & Ewert, M. (1993). Pathological grief: An intensive case study. *Psychiatry, Interpersonal and Biological Processes, 56*, 356–374.

Jacobs, S. C. (1987). Psychoendocrine aspects of bereavement. In S. Zisook (Ed.), *Biopsychosocial aspects of bereavement* (pp. 139–155). Washington, DC: American Psychiatric Association Press.

Jacobs, S. C. (1993). *Pathological grief: Maladaptation to loss*. Washington, DC: American Psychiatric Association Press.

Jacobs, S., & Lieberman, P. (1987). Bereavement and depression. In O. G. Cameron (Ed.), *Presentations of depression: Depressive symptoms in medical and other psychiatric disorders* (pp. 169–184). New York: Wiley.

Jacobs, S., Mazure, C., & Prigerson, H. (2000). Diagnostic criteria for traumatic grief. *Death Studies, 24*, 185–199.

Jacobs, S., & Prigerson, H. (2000). Psychotherapy of traumatic grief: A review of evidence for psychotherapeutic treatments. *Death Studies, 24*, 479–495.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.

Kennedy, H. P. (2004). Enhancing Delphi research: Methods and results. *Journal of Advanced Nursing, 45*, 504–511.

Latham, A.E., & Prigerson, H.G. (2004). Suicidality and bereavement: Complicated grief as psychiatric disorder presenting greatest risk for suicidality. *Journal of Suicide and Life Threatening Behavior, 34*(4) Winter.

Lindy, J. D., Green, B. L., Grace, M., & Titchener, J. (1983). Psychotherapy with survivors of the Beverly Hills Supper Club fire. *American Journal of Psychotherapy, 37*, 593–610.

Maercker, A., Bonanno, G. A., Znoj, H., & Horowitz, M. J. (1998). Prediction of complicated grief by positive and negative themes in narratives. *Journal of Clinical Psychology, 54*, 1117–1136.

Marwit, S. J. (1991). DSM-III-R, grief reactions, and a call for revision. *Professional Psychology, Research and Practice, 22*, 75–79.

Marwit, S. J. (1996). Reliability of diagnosing complicated grief: A preliminary investigation. *Journal of Consulting and Clinical Psychology, 64*, 563–568.

Marwit, S. J., & Klass, D. (1995). Grief and the role of the inner representation of the deceased. *Omega: Journal of Death and Dying, 30*, 283–298.

Mawson, D., Marks, I. M., Ramm, L., & Stern, R. S. (1981). Guided mourning for morbid grief: A controlled study. *British Journal of Psychiatry, 138*, 185–193.

McDermott, O. D., Prigerson, H. G., Reynolds, C. F., Houck, P. R., Dew, M. A., Hall, M., et al. (1997). Sleep in the wake of complicated grief symptoms: An exploratory study. *Biological Psychiatry, 41*, 710–716.

Meehl, P. E. (2004). What's in a taxon? *Journal of Abnormal Psychology, 113*, 39–43.

Neimeyer, R. A. (2000). Grief therapy and research as essential tensions: Prescriptions for a progressive partnership. *Death Studies, 24*, 603–610.

Neimeyer, R. A. (2001). Reauthoring life narratives: Grief therapy as meaning reconstruction. *Israel Journal of Psychiatry and Related Sciences, 38*, 171–183.

Neimeyer, R. A., Prigerson, H. G., & Davies, B. (2002). Mourning and meaning. *American Behavioral Scientist, 46*, 235–251.

Ogrodniczuk, J. S., Piper, W. E., Joyce, A. S., Weideman, R., McCallum, M., Azim, H. F., et al. (2003). Differentiating symptoms of complicated grief and depression among psychiatric outpatients. *Canadian Journal of Psychiatry, 48*, 87–93.

Ott, C. (2003). The impact of complicated grief on mental and physical health at various points in the bereavement process. *Death Studies, 27*, 249–272.

Pasternak, R. E., Reynolds, C. F., Frank, E., Miller, M., Houck, P. R., Schlernitzauer, M., et al. (1993). The temporal course of depressive symptoms and grief intensity in late-life spousal bereavement. *Depression, 1*, 45–49.

Pasternak, R. E., Reynolds III, C. F., Schlernitzauer, M., Hoch, C. C., Buysse, D. J., Houck, P. R., et al. (1991). Acute open-trial nortriptyline therapy of bereavement-related depression in late life. *Journal of Clinical Psychiatry, 52*, 307–310.

Prigerson, H. G. (2002). *Measuring complicated grief*. Retrieved December 4, 2002 from http://info.med.yale.edu/psych/cgrief/measure_CG.htm.

Prigerson, H. G., Ahmed, I., Saxena, A. K., Maciejewski, P. K., Jacobs, S. C., & Kasl, S. V. (2002). Rates and risks of complicated grief among psychiatric clinic patients in Karachi, Pakistan. *Death Studies, 26*, 781–792.

Prigerson, H. G., Bierhals, A. J., Kasl, S. V., Reynolds III, C. F., Shear, M. K., Newson, J. T., et al. (1996). Complicated grief as a disorder distinct from bereavement-related depression and anxiety: A replication study. *American Journal of Psychiatry, 153*, 1484–1486.

Prigerson, H. G., Bierhals, A. J., Kasl, S. V., Reynolds III, C. F., Shear, M. K., Day, N., et al. (1997). Traumatic grief as a risk factor for mental and physical morbidity. *American Journal of Psychiatry, 154*, 616–623.

Prigerson, H. G., Frank, E., Kasl, S. V., Reynolds III, C. F., Anderson, B., Zubenko, G. S., et al. (1995). Complicated grief and bereavement-related depression as distinct disorders: Preliminary empirical validation in elderly bereaved spouses. *American Journal of Psychiatry, 152*, 22–30.

Prigerson, H. G., & Jacobs, S. C. (2001a). Traumatic grief as a distinct disorder: A rationale, consensus criteria, and a preliminary empirical test. In M. S. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 613–645). Washington, DC: American Psychological Association.

Prigerson, H. G., & Jacobs, S. C. (2001b). Caring for bereaved patients: "All the doctors just suddenly go". *JAMA Journal of the American Medical Association, 286*, 1369–1375.

Prigerson, H. G., Jacobs, S. C., Rosenheck, R. A., & Maciejewski, P. K. (1999). "Criteria for traumatic grief and PTSD": Reply. *British Journal of Psychiatry, 174*, 560–561.

Prigerson, H. G., Maciejewski, P. K., Reynolds III, C. F., Bierhals, A. J., Newsom, J. T., Fasiczka, A., et al. (1995). Inventory of Complicated Grief: A scale to measure maladaptive symptoms of loss. *Psychiatry Research, 59*, 65–79.

Prigerson, H. G., Shear, M. K., Bierhals, A. J., Pilkonis, P. A., Wolfson, L., Hall, M., et al. (1997). Case histories of traumatic grief. *Omega-Journal of Death & Dying, 35*, 9–24.

Prigerson, H. G., Shear, M. K., Frank, E., & Beery, L. C. (1997). Traumatic grief: A case of loss-induced trauma. *American Journal of Psychiatry, 154*, 1003–1009.

Prigerson, H. G., Shear, M. K., Jacobs, S. C., Kasl, S. V., Maciejewski, P. K., Silverman, G. K., et al. (2000). Grief and its relationship to PTSD. In D. Nutt, & J. R. T. Davidson (Eds.), *Post traumatic stress disorders: Diagnosis, management and treatment* (pp. 163–186). New York: Martin Dunitz.

Prigerson, H. G., Shear, M. K., Jacobs, S. C., Reynolds, C. F., III, Maciejewski, P. K., & Davidson, J. R. T. (1999). Consensus criteria for traumatic grief: A preliminary empirical test. *British Journal of Psychiatry, 174*, 67–73.

Prigerson, H. G., Shear, M. K., Newsom, J. T., Frank, E., Reynolds, C. F., III, Houck, P. R., et al. (1996). Anxiety among widowed elders: Is it distinct from depression and grief? *Anxiety, 2*, 1–12.

Prigerson, H. G., Silverman, G. K., Jacobs, S. C., Maciejewski, P. K., Kasl, S. V., & Rosenheck, R. A. (2001). Traumatic grief, disability, and the underutilization of health services: A preliminary examination. *Primary Psychiatry, 8*, 61–66.

Pynoos, R. S., Nader, K., Frederick, C., Gonda, L., & Stuber, M. (1987). Grief reactions in school age children following a sniper attack at school. *Israel Journal of Psychiatry and Related Sciences, 24*, 53–63.

Rando, T. A. (2000). Clinical dimensions of anticipatory mourning. Champaign, IL: Research.

Raphael, B. (1997). The interaction of trauma and grief. In D. Black, Newman M., et al., (Eds.), *Psychological trauma: A developmental approach* (pp. 31–43). Washington, DC: American Psychiatric Association.

Raphael, B., & Martinek, N. (1997). Assessing traumatic bereavement and posttraumatic stress disorder. In J. P. Wilson, & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 373–395). New York, NY: The Guilford Press.

Reynolds, C. F., Miller, M. D., Pasternak, R. E., Frank, E., Perel, J. M., Cornes, C., et al. (1999). Treatment of bereavement-related major depressive episodes in later life: A controlled study of acute and continuation treatment with nortriptyline and interpersonal psychotherapy. *American Journal of Psychiatry, 156*, 202–208.

Ringdal, G. I., Jordhoy, M. S., Ringdal, K., & Kaasa, S. (2001). The first year of grief and bereavement in close family members to individuals who have died of cancer. *Palliative Medicine, 15*, 91–105.

Robins, E., & Guze, S. B. (1970). Establishment of diagnostic validity in psychiatric illness: Its application to schizophrenia. *American Journal of Psychiatry, 126*, 983–987.

Robinson, L. A., Berman, J. S., & Neimeyer, R. A. (1990). Psychotherapy for the treatment of depression: A comprehensive review of controlled outcome research. *Psychological Bulletin, 108*, 30–49.

Rosenzweig, A., Prigerson, H., Miller, M. D., & Reynolds III, C. F. (1997). Bereavement and late-life depression: Grief and its complications in the elderly. *Annual Review of Medicine, 48*, 421–428.

Sable, P. (1992). Attachment, loss of spouse, and disordered mourning. *Families in Society, 73*, 266–273.

Sanders, C. M. (1993). Risk factors in bereavement outcome. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 175–195). Washington, DC: American Psychological Association.

Schlemitzauer, M., Bierhals, A. J., Geary, M. D., Prigerson, H. G., Stack, J. A., Miller, M. D., et al. (1998). Recruitment methods for intervention research in bereavement-related depression. *American Journal of Geriatric Psychiatry, 6*, 67–74.

Schuchter, S. R., Zisook, S., Kirkorowicz, C., & Risch, C. (1986). The dexamethasone test in acute grief. *American Journal of Psychiatry, 143*, 879–881.

Shear, M. K., Frank, E., Foa, E., Cherry, C., Reynolds III, C. F., Vander Bilt, J., et al. (2001). Traumatic grief treatment: A pilot study. *American Journal of Psychiatry, 158*, 1506–1508.

Silverman, G. K., Jacobs, S. C., Kasl, S. V., Shear, M. K., Maciejewski, P. K., Noaghiul, F. S., et al. (2000). Quality of life impairments associated with diagnostic criteria for traumatic grief. *Psychological Medicine, 30*, 857–862.

Silverman, G. K., Johnson, J. G., & Prigerson, H. G. (2001). Preliminary explorations of the effects of prior trauma and loss on risk for psychiatric disorders in recently widowed people. *Israel Journal of Psychiatry and Related Sciences, 38*, 202–215.

Simpson, M. A. (1997). Traumatic bereavements and death-related PTSD. In C. R. Figley, B. E. Bride, & N. Mazza (Eds.), *Death and trauma: The traumatology of grieving* (pp. 3–16). Washington, DC: Taylor & Francis.

Spitzer, R. L., Williams, J. B. W., Gibbon, M., & First, M. B. (1990). Structured clinical interview for DSM-III-R—non-patient edition (SCID-NP, Version 1.0). Washington, DC: American Psychiatric Press.

Spooren, D. J., Henderick, H., & Jannes, C. (2000/2001). Survey description of stress of parents bereaved from a child killed in a traffic accident. A retrospective study of a victim support group. *Omega-Journal of Death & Dying, 42*, 171–185.

Stroebe, M. S., & Stroebe, W. (1993). The mortality of bereavement: A review. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 175–195). Washington, DC: American Psychological Association.

Stroebe, M., Schut, H., & Finkenauer, C. (2001). The traumatization of grief? A conceptual framework for understanding the trauma–bereavement interface. *Israel Journal of Psychiatry and Related Sciences, 38*, 185–201.

Stroebe, M., van Son, M., Stroebe, W., Kleber, R., Schut, H., & van den Bout, J. (2000). On the classification and diagnosis of pathological grief. *Clinical Psychology Review, 20*, 57–75.

Szanto, K., Prigerson, H., Houck, P., Ehrenpreis, L., & Reynolds III, C. F. (1997). Suicidal ideation in elderly bereaved: The role of complicated grief. *Suicide & Life-Threatening Behavior, 27*, 194–207.

Vanderwerker, L. C., Jacobs, S. C., Parkes, C. M., & Prigerson, H. G. (2004). Childhood separation anxiety as risk for complicated grief in later-life. Manuscript submitted for publication.

van Doorn, C., Kasl, S. V., Beery, L. C., Jacobs, S. C., & Prigerson, H. G. (1998). The influence of marital quality and attachment styles on traumatic grief and depressive symptoms. *Journal of Nervous and Mental Disease, 186*, 566–573.

Worden, J. W. (1986). Grief counseling and grief therapy: A handbook for the mental health practitioner. New York: Springer.

Zisook, S., & Devaul, R. A. (1983). Grief, unresolved grief, and depression. *Psychosomatics, 24*, 247–256.

Zisook, S., Schneider, D., & Schuchter, S. (1990). Anxiety and bereavement. *Psychiatric Medicine, 8*, 583–596.

Zisook, S., & Schuchter, S. (1991). Depression through the first year after the death of a spouse. *American Journal of Psychiatry, 148*, 1346–1352.

Zygmont, M., Prigerson, H. G., Houck, P. R., Miller, M. D., Shear, M. K., Jacobs, S., et al. (1998). A post hoc comparison of paroxetine and nortriptyline for symptoms of traumatic grief. *Journal of Clinical Psychiatry, 59*, 241–245.